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Thomas P Kirwin Site Vice President

PNP 2011-026

March 23, 2011

U. S. Nuclear Regulatory Commission

ATTN: Document Control Desk Washington, DC 20555-0001

SUBJECT:

Licensee Event Report 2011-002, Automatic Reactor Trip and

Auxiliary Feedwater System Actuation

Palisades Nuclear Plant

Docket 50-255

License No. DPR-20

REFERENCES:

10 CFR 50.73

Dear Sir or Madam:

Licensee Event Report (LER) 2011-002 is enclosed. The LER describes an automatic actuation of the reactor protection system and the auxiliary feedwater system. The occurrence is reportable in accordance with 10 CFR 50.73(a)(2)(iv)(A).

This letter contains no new commitments and no revisions to existing commitments.

Sincerely, Thomas Kniver

TPK/TAD

Enclosure (1)

CC Administrator, Region III, USNRC

Project Manager, Palisades, USNRC

Resident Inspector, Palisades, USNRC

ENCLOSURE

LER 2011-002

AUTOMATIC REACTOR TRIP AND AUXILIARY FEEDWATER SYSTEM ACTUATION

U.S. NUCLEAR REGULATORY COMMISSION

(10-2010)

NRC FORM 366A

LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

CONTINUATION CHEET										
1. FACILITY NAME	2. DOCKET	6. LER NUMBER				X				
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER						
PALISADES NUCLEAR PLANT	05000255	2011	- 002 -	00	2	OF	3			

EVENT DESCRIPTION

On January 22, 2011, at 1735 hours, with the plant in Mode 1 at 100% power, the operation of relay 251-2/SPG3 [51;EA], station power transformer 1-3 neutral to ground, actuated relay 386B [86;EA], generator direct trip lockout relay (backup), opening the main generator output breakers [BKR;FK] to the transmission system causing a turbine [TRB;EL] trip. The turbine trip actuated the reactor protective system [JD] to trip the reactor [RCT;AB] due to a loss of load. As expected, the auxiliary feedwater system [BA] started automatically to recover steam generator [SG;AB] level.

There were no inoperable structures, systems, or components at the start of this event that contributed to the event.

The event is reportable in accordance with 10 CFR 50.73(a)(2)(iv)(A) as an event that resulted in an actuation of both the reactor protection system and the auxiliary feedwater system.

CAUSE OF THE EVENT

An event evaluation determined the cause for operation of the neutral to ground relay, and subsequent automatic plant trip, was a ground fault on a medium voltage cable [CBL5] providing electrical power to bus 1G, via breaker 252-401, from station power transformer 1-3. The probable cause of the ground fault on the cable was determined to be flaws in the insulation, with the effects of moisture acting on these flaws over time, causing the insulation to degrade. The shielded cable, manufactured by Cablec with ethylene propylene rubber (EPR) insulation, was installed in 1989 with the expected lifetime to be much longer than exhibited.

The evaluation identified additional causes that include ineffective use of operating experience related to medium voltage cable insulation problems, and testing methods that were incapable of trending insulation condition to support repair and/or replacement.

The cable has not been removed and physically examined. Therefore, the cause of the suspected flaw(s) in the insulation is unknown at this time. Cable removal and analysis is planned.

CORRECTIVE ACTIONS TAKEN

A temporary modification was approved and implemented that allows bus 1G to be isolated from station power transformer 1-3 and re-energized from start-up transformer 1-3.

CORRECTIVE ACTIONS TO BE TAKEN

A plan is being developed to remove samples of the failed cable for laboratory testing and analysis.

NRC FORM 366A (10-2010)	U.S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT (LER) CONTINUATION SHEET							
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The original design will be restored to allow supply of power to bus 1G from station power transformer 1-3.

A condition monitoring method will be established which will identify progressive deteriorization of medium voltage shielded cable insulation.

Monitoring plans will be created for buried medium voltage shielded, and unshielded, cables that will provide timely identification of adverse insulation changes.

ASSESSMENT OF SAFETY CONSEQUENCES

The event is considered to be of very low safety significance. All safety systems functioned as expected.

PREVIOUS SIMILAR EVENTS

None